

**CENTRAL VIRGINIA TRAINING CENTER**  
**LYNCHBURG, VIRGINIA**

**PRIMARY INSPECTION**

**OFFICE OF THE**  
**INSPECTOR GENERAL**

**EXECUTIVE SUMMARY**

The following findings constitute a summary and would be taken out of context if interpreted without review of the accompanying background material.

**FINDINGS OF MERIT**

**Finding 1.1:** Throughout numerous observations while at CVTC staff was observed to have appropriate individual interactions with residents.

**Finding 1.2:** The advocates at CVTC are proactive in developing relationships with staff and residents.

**Finding 1.3:** CVTC promotes an environment that recognizes and supports the value of individual resident choice.

**Finding 2.1:** The use of locked time-out is prohibited at this facility.

**Finding 3.1:** Individualized active treatment is provided that is based on specific client needs as identified through review of objective and supported observational data by a knowledgeable interdisciplinary team.

**Finding 3.2:** The Treatment plans reviewed at CVTC were comprehensive, individualized and community oriented.

**Finding 3.3:** Transition support guides and other documents have been created for individuals that are targeted for possible transfer into the community.

**Finding 4.1:** The staff at CVTC provides a warm and caring treatment milieu for a challenging and disparate client population.

**Finding 5.1:** CVTC has a system in place to provide primary care to its residents on a regular basis.

**Finding 5.2:** CVTC has one full-time psychiatrist who is based at the Shenandoah Center.

**Finding 6.1:** CVTC has collaborative relationships with several colleges and universities throughout the Commonwealth.

**Finding 7.1:** Over the last two years CVTC has developed an extensive nutrition management program for every resident.

### **FINDINGS OF CONCERN**

**Finding 4.2:** Finding 4.2: The living units and many program spaces at CVTC present as a harsh institutionalized environment.

**Finding 4.3:** Residents at CVTC experience more injuries than residents of other facilities.

**Finding 5.3:** Access to psychiatric services for residents outside the unit where the psychiatrist is housed may be compromised due to only one psychiatrist being available for the entire facility.

**Finding 7.2:** Eating Precaution Program (EPP) cards were in evidence on the units observed during mealtime, but not always used appropriately.

**Finding 8.1:** The majority of staff interviewed identified the "aging" of both staff and clients as a significant challenge for the Center.

**Finding 8.2:** Recent admissions have been more behaviorally and psychiatrically complex than in the past.

**Finding 8.3:** Staff voice concern about the community's ability to provide adequate care to CVTC residents upon discharge.

**Finding 8.4:** There is a shortage of staff at all levels and with the aging of staff this will become more critical in the next several years.

**Finding: 8.5: Forty-two per cent of all residents live in congregate living centers housing more than 17 residents.**

**Facility:** Central Virginia Training Center

**Date:** July 11 – 13, 2000

**Type of Inspection:** Primary Inspection / Unannounced

**Reviewers:** Anita Everett, MD

Laura Desportes Echols, Ph.D.

Cathy Hill, M.Ed.

**Purpose of the Inspection:** To conduct a comprehensive inspection of the facility as an aspect of routine on-going quality reviews.

**Sources of Information:** Interviews were conducted with staff, ranging from members in leadership positions to direct-care workers. Documentation reviews included, but was not limited to: resident treatment records, selected Policies and Procedures, selected committee minutes, facility training materials, Performance Improvement/QA projects, and statistics regarding resident complaints. Activities and staff/resident interactions were observed.

**Areas Reviewed:** Section One / Treatment with Dignity and Respect

Section Two / Locked Time-out and Restraint

Section Three / Active Treatment

Section Four / Treatment Environment

Section Five / Access to Medical Care

Section Six / Public--Academic Relationships

Section Seven / Notable Administrative Activities

Section Eight / Facility Challenges

**INTRODUCTION:**

This report summarizes the findings during a primary inspection of Central Virginia Training Center, which occurred from July 11 – 13, 2000.

Primary inspections are routine unannounced comprehensive visits to the mental health and mental retardation facilities operated by the Commonwealth of Virginia. The purpose of these inspections is to evaluate components of the quality of care delivered by the facility and to make recommendations regarding performance improvement.

Currently there are many forces addressing severe deficiencies in the public funded Mental Health, Mental Retardation and Substance Abuse (MHMRAS) Facility System in Virginia. The items identified for review in this report were selected based on the relevance to current reform activity being undertaken in Central Virginia Training Center as well as other facilities in Virginia. This report intentionally focused on those issues that relate most directly to the quality of professional care provided to patients of the facility. It is intended to provide a view into the current functioning of the training center.

This report is organized into eight different areas. These are: 1) Treatment of Patients with Dignity and Respect, 2) Use of Locked Time-out and Restraint, 3) Active Treatment, 4) Treatment Environment, 5) Access to Medical Services, 6) Public-Academic Relationships, 7) Notable Administrative Projects and 8) Facility Challenges. Under each of these areas are one or more “findings” with related background discussion and recommendations.

## **FACILITY BACKGROUND INFORMATION:**

Central Virginia Training Center is the largest institution within the Commonwealth and the largest of the five centers providing services for persons with mental retardation. This facility began operations in 1911 and at one time in its history had a population of 3600. The current census is approximately 665 consumers. The majority of consumers are served in the program certified as an intermediate care facility (ICF-MR). The facility is certified to provide skilled nursing care, intermediate care and supported living/specialized foster community care. There is a medical center on grounds, which provides acute and convalescent care for more medically impaired individuals.

The training center is located in Amherst County on approximately 270 acres. The Center provides services primarily to twelve community services boards that serve seven counties and three cities. Admissions and discharges from elsewhere across the Commonwealth sometimes occur.

## SECTION ONE

### TREATMENT WITH DIGNITY AND RESPECT

**Finding: 1.1 Throughout numerous observations while at CVTC staff were observed to have appropriate individual interactions with residents.**

Background: A variety of staff-resident interactions were observed in multiple settings across the facility. On the living unit, residents were up and about, smiling, interacting with staff, and demonstrating genuine reciprocal affection. Most staff had spent many years at the Center and spoke fondly and knowledgeably of the residents with whom they worked. Staff were observed reading to residents, interacting appropriately, and speaking very positively about residents, even those who have exhibited very severe aggressive behaviors. The staff spoke with great pride of a resident who had recently “graduated” from the special education program. This is a resident who has had multiple admissions to the Center and to a public psychiatric facility due to his severe aggression, yet staff spoke of him as “a great guy” and were proud of his accomplishments.

**Recommendation: Offer support to staff who demonstrate caring and compassionate interactions in their relationship and work with residents.**

---

**Finding 1.2: The advocates at CVTC are proactive in developing relationships with staff and residents.**

Background: The advocates related that one of their objectives is to complete routine rounds of all the residential units so that they can interact with the clients and staff. This allows them to have frequent observation of the clients and their status. The human rights staff feel that this contact is extremely important in assuring the rights of the client who have limited ability to advocate for themselves.

The visible presence of the advocates on the living units serves as a reminder to staff of the importance of providing care for the client that is imparted with dignity and respect while devoid of neglect and abuse.

There are currently three human rights advocates for the approximately 665 clients at the facility at the time of the inspection. There is an active local human rights committee (LHRC). Over the past year, the LHRC was in a rebuilding process in order to provide adequate consumer representation on the committee.

**Recommendation: It is recommended that the human rights advocates continue to devote a significant portion of their time to direct client contact and observation in order to promote treatment with dignity that is free of abuse and neglect.**

---

**Finding 1.3: CVTC promotes an environment that recognizes and supports the value of individual resident choice.**

Background : The value placed on resident choice and empowerment was evident across multiple living areas and across varying levels of staff, from the Center Director, down to direct care staff. Staff were aware of activity preferences, companionship preferences, and food preferences of the residents with whom they worked. Staff reported that they knew the residents well enough to seek to actively engage “those who need it, and to leave alone those who need space.”

**Recommendation: Continue to promote a treatment environment that promotes client choice while maximizing independence.**

<b>SECTION TWO</b>
--------------------

<b>THE USE OF LOCKED TIMEOUT AND RESTRAINT</b>
--

**Finding 2.1: The use of locked time-out is prohibited at this facility.**

Background: CVTC by policy prohibits the use of locked time-out at this facility. The facility prohibits any behavioral intervention that prohibits egress of the client. There are no rooms at the facility designated for the use of time-out.

Locked time-out is the more traditional process used in other centers whereby residents who are experiencing behavioral difficulties are removed from the stimulating situation and placed in a room which is secured by staff. The doors are equipped with a handle lock that will not stay shut unless held in place by a staff. Behavioral management plans are developed for those individuals exhibiting behavioral difficulties. The advocates and the LHRC review the behavioral management plans prior to implementation.

CVTC prefers the use of exclusionary time out. When a resident is having difficulty with disruptive behavior in a group setting, the staff will attempt to remove the resident from the stimulus condition. This may mean removing other residents who are in the vicinity, or it may mean physically removing the disruptive resident. The premise is that the setting itself is reinforcing the inappropriate behavior and that removing the reinforcing condition should result in the termination of the inappropriate behavior. The resident is removed from the setting and redirected toward a more private setting, but is not taken to a Time Out room or other seclusion area.

**Recommendation: None.** While we support the behavioral principle involved with exclusionary time out, we did not have the opportunity to directly observe the actual practice of this at CVTC. It may be useful for psychology staff to initiate an intrafacility peer review system as a performance improvement project wherein direct care staff adherence to exclusionary time out and other behavior treatment plans are reviewed.

### SECTION THREE

#### ACTIVE TREATMENT

**Finding 3.1: Individualized active treatment is provided that is based on specific client needs as identified through review of objective and supported observational data by a knowledgeable interdisciplinary team.**

Background: Active treatment is required for all clients of beds certified by Medicaid at the ICF/MR level of care. Treatment must be individualized based on needs of the client's that are currently identified as preventing his or her living in a less restrictive environment. All programs are aimed toward the client's return to a community placement and focus on self-help, vocational, and pro-social adaptive behavior skills.

Program Centers at CVTC are certified at the ICF/MR level of care and several other living areas are also certified as Skilled Nursing Facilities. The facility also offers community-based services in-group homes and supported living programs though only programs offered on grounds were observed during this inspection. Active treatment programs are carried out in a variety of environmental settings based on the adaptive skills of the clients, behavioral and medical factors, and the nature of the programs provided.

**Recommendation: It is recommended that staff continue to provide individualized active treatment that is based on clients' needs but to keep in mind that the immediate goal of that treatment is movement to the next less restrictive setting.**

---

**Finding 3.2: The Treatment plans reviewed at CVTC were comprehensive, individualized and community oriented.**

Background: The treatment plans of several residents known to be challenging were reviewed. The plans were found to be comprehensive and individualized. The plans

include reference to the supports that would be necessary for successful adjustment to non-facility based life.

**Recommendation: Continue to document care and create treatment plans in this manner.**

---

**Finding 3.3: Transition support guides and other documents have been created for individuals that are targeted for possible transfer into the community.**

Background: The charts of several individuals that have been targeted for transfer into the community were reviewed. Extensive practical documentation has been prepared by CVTC staff that is designed to help community support staff develop knowledge of the individuals. One example of this is the “Transition Support Guide” that contains details regarding: 1.) what works (makes the client happy); 2.) what does not work, (makes him feel unhappy or unsuccessful); 3.) gifts and attributes (what people who know him think about him); and 4. ) barriers to acceptance (what gets in the way of knowing and caring).

**Recommendations: None. The preparation of these documents helps to foster the individualized treatment planning culture at CVTC, as well as educating community support staff about individual needs and personality of consumers.**

<b>SECTION FOUR</b>
---------------------

<b>TREATMENT ENVIRONMENT</b>
------------------------------

**Finding 4.1: The staff at CVTC provide a warm and caring treatment milieu for a challenging and disparate client population.**

Background: CVTC has a large number of staff who have been there for many years. The range of tenure for direct care staff interviewed was from 16 years to 27 years. Many staff, including the Facility Director who has been there over thirty years, are second generation employees of CVTC. In addition, facility statistics indicated that 81% of clients have lived there more than 20 years. This creates an environment where staff and clients have developed a culture that fosters a strong feeling of caring and commitment. This results in a close-knit, asylum-like community for clients. This also fosters a reluctance on the part of staff to discharge clients to a community that they perceive as less committed and with fewer resources to serve their clients.

The majority of more recent admissions to CVTC are young adults with histories of severe behaviors that are not able to be managed successfully in a community setting. Since the enactment of Individuals with Disabilities Educational Act in 1974, most individuals with mental retardation and other developmental delays are served within the public school system. When these individuals become young adults, and age out of school, there is at times a transition and change in structure and schedule such that previous levels of care and providers are no longer available or appropriate. The primary type of behavior that is difficult to manage in community settings is aggression.

Many staff cited examples of recent admissions that came in over-medicated and inappropriately medicated in failed attempts to manage their aggressive behavior. The most recent example was a re-admission that came in on 7 medications. A member of the psychology staff characterized many new admissions as dually diagnosed (psychiatric diagnosis along with mental retardation) or people with violent behaviors who have never had any formal behavioral intervention. This concern was also voiced by the Facility Director, Medical Director, and by many other key staff who have observed this change over many years. These clients require intensive staffing including a level of psychiatric support normally found in a mental health hospital.

**Recommendation: None. Continue to support staff who have dedicated their careers to working in this environment.**

---

**Finding 4.2: The living units and many program spaces at CVTC present as a harsh institutionalized environment.**

Background: CVTC is the largest facility in the Commonwealth and reflects a highly institutional feel. The outside presents beautifully, but the interiors are concrete, tile, and cinderblock. Attempts have been made in several of the living areas to create a homelike atmosphere through the addition of curtains, individual comforters and artwork. Others remain quite stark and sterile. In many living centers observed, all of the residents' dresser drawers and wardrobes were padlocked to prevent access without supervision. While this is understandable given the nature of some of the residents, it is an institutional solution to an individual management problem.

**Recommendation: Consideration should be given to the development of an initiative, investigating ways to develop a less institutional atmosphere within the living centers.**

---

**Finding 4.3: Residents at CVTC experience more injuries than residents of other facilities.**

Background: The population of medically fragile and aging clients who have resided at the facility most of their lives presents a significant challenge to CVTC. These clients are at great risk of self-injury. A likely contributing factor to this is the design and materials of the physical surroundings and furniture, and their own physical limitations and fragility. This creates a tension between providing protection to clients and a desire to maximize their mobility and independence. The “cargo style” furniture that was designed to withstand the abuse of younger, higher functioning clients, now poses a hazard for the older and frailer clients.

**Recommendation: Continue to monitor the environment with regard to safety for a frail population.**

<b>SECTION FIVE</b>
---------------------

<b>ACCESS TO MEDICAL CARE</b>
-------------------------------

**Finding 5.1: CVTC has a system in place to provide primary care to its residents on a regular basis.**

Background: There are 7 physicians and one Nurse Practitioner at CVTC. The formal training of these physicians include an OB-GYN, three pediatricians, one pathologist, one surgeon, and one General Practitioner. CVTC has been recruiting for an internist, but at the time of this inspection was unable to fill this position. The addition of an internist would enhance the facility’s ability to provide medical care for more medically complex residents. No staff that we interviewed reported difficulty with access to the assigned primary care physician.

**Recommendation: Continue to recruit for an internist.**

---

**Finding 5.2: CVTC has one full-time psychiatrist who is based at the Shenandoah Center.**

Background: The psychiatrist has his office in Shenandoah Center, and works from this unit. This has been a relatively recent change within the unit and seems to be quite successful. Staff reports that they have good access to the psychiatrist. Of particular

benefit is his availability to attend frequent clinical team meetings and participation in treatment planning. This means that if a resident has developed a sudden change in clinical status, he is likely to be able to be seen immediately by professionals who know him well.

**Recommendation: None. This arrangement seems to be working well for the residents in this center.**

---

**Finding 5.3: Access to psychiatric services for residents outside the unit where the psychiatrist is housed may be compromised due to only one psychiatrist being available for the entire facility.**

Background: Several of the charts reviewed from units other than the Shenandoah Center revealed only an annual visit by the consulting psychiatrist. With more individual attention from a psychiatrist with experience in this clinical area, medications may be better able to be used to treat certain psychiatric symptoms thereby improving quality of life for the individual.

Because many of these individuals do not express themselves in traditional ways, following the response to medication is very intensive and involves following data, input from various levels of direct care staff, and integrating this with the preferences of the individual as well as their family or authorized representative. No one wants to see the indiscriminate use of tranquilizing medication to blanket behavior. However, there are many new medications now available that may have a role together with well-developed behavior treatment plans in reducing dangerously impulsive behavior. Increasing the psychiatry time at CVTC would allow more access by all residents to a psychiatrist and would allow for consultation between psychiatrists.

**Recommendation: Consider mechanisms for increasing access to the psychiatrist such that every resident currently on or in need of psychoactive medication have access to a psychiatrist a minimum of one face-to-face visit every three months.**

## SECTION SIX

### PUBLIC-ACADEMIC RELATIONSHIPS

**Finding 6.1: CVTC has collaborative relationships with several colleges and universities throughout the Commonwealth.**

Background: Working with students from a variety of professions provides a service to the educational institutions within Virginia. Additionally this provides opportunities for individuals to become acquainted with and exposed to the challenges and rewards associated with working with mentally retarded persons. CVTC has current contracts to accept students from the following colleges/universities and their respective programs:

Old Dominion University	Family Nurse Practitioner program
Virginia Commonwealth University	Social Work
Virginia Commonwealth University	Dental
Virginia Commonwealth University	Pharmacy
James Madison University	Occupational Therapy
(ANITA-- I don't believe that JMU has an OT program, but that's what's listed)	
College of Health Sciences	COTA/LPTA
Liberty University	Psychology/Special Education
Lynchburg College	Special Education
Miller Mott Business School	Medical Records
Centra Health	Nursing
Campbell County VoTech	Nursing Assistants
University of Virginia	Speech
Virginia Tech	Speech
Radford University	Speech
Amherst Co. Public Schools	GED
Lenoir-Rhyne, N.C.	Occupational Therapy

In addition, contract arrangements are near completion with East Tennessee State University to accept Physical Therapy program students and with J. Sargeant Reynolds Community College to accept COTA/LPTA students.

**Recommendations: Continue to support public-academic relationships through providing internship and practicum sites as well as supporting research within the facility.**

## SECTION SEVEN

### NOTABLE ADMINISTRATIVE PROJECTS

**Finding 7.1: Over the last two years CVTC has developed an extensive nutrition management program for every resident.**

Background: The Nutrition Management Program at CVTC is overseen by the Speech Pathologists. This was a dramatic change in their role at the center. Each resident is evaluated and a score is established based on the determined severity of impairment. Re-evaluations are based on these scores with higher scores being assigned to those with the most severe impairments. Re-evaluations occur every six to twelve months for the most severely impaired and triennially for those with no impairment. Re-evaluations are being incorporated into the annual review process.

In addition to the direct benefits of improved nutrition, there are many indirect benefits that have been realized from this program. The primary benefit is the obvious sense of self esteem that is associated with new levels of independence associated with feeding themselves, even though this takes longer, rather than being fed. Another benefit is a broader appreciation for a residents' medical needs that may interfere with swallowing and efficient and safe eating. This program has also been seen as an opportunity to explore individual resident preferences with regards to food choices.

**Recommendations: Continue to support this meaningful and effective project.**

---

**Finding 7.2: Eating Precaution Program (EPP) cards were in evidence on the units observed during mealtime, but not always used appropriately.**

Background Information: Eating plans are critical for CVTC residents in order to prevent aspiration, malnutrition, and choking. These plans are summarized on a card with the client's photograph, the EPP card. EPP cards are developed for all residents and describe their recommended feeding plans. While EPP cards were in evidence at mealtimes, the correct EPP card was not always present at the same place setting as the resident. This would make it difficult to follow program recommendations if staff were unfamiliar with the resident or if recent changes had been made in the program. Additionally, the specifications on the cards were not always being followed. These are most likely related

to the newness of the program, and turnover in staffing. The Qualified Mental Retardation Professional (QMRP), who functions as a case manager for a given set of residents, is assigned to monitor and supervise feeding in each dining area on each unit, at least once a week. It is hoped that these QMRPs provide information on implementation of the programs as well as barriers to the implementation of these programs so that unpractical program elements can be reworked to facilitate staff following these programs.

**Recommendations: Continue exchange feedback with direct care staff in the correct implementation of this valuable program.**

## **SECTION EIGHT**

### **FACILITY CHALLENGES**

**Finding 8.1: The majority of staff interviewed identified the "aging" of both staff and clients as a significant challenge for the Center.**

Background: Staff of all disciplines indicated that both the aging of the clients served by the facility and the "aging" of staff present unique challenges for the facility. Reportedly, a significant number of staff members will be reaching retirement age within the next several years resulting in, as those interviewed defined, a "mass exodus" of trained knowledgeable staff with significant longevity. All expressed concern for the continued stability of the program with the extent of change in key positions the retirements may represent.

The majority of residents at CVTC are diagnosed with severe to profound mental retardation, often with multiple other disabling conditions. Although staff indicated that more than half of those served by the facility could be discharged to the community, adequate supports for successful transition are not currently in place. Individuals with MR/DD are living longer now than in the past. This extended life expectancy for members of this population has resulted in an older resident group that are now confronted with the issues associated with all aging populations. Some of these concerns include decreased sensory awareness, compromised mobility, and increased risks of falls and injuries as well as general decline in health and functioning. In addition, the physical plant at CVTC poses a harsh, unforgiving environment for fragile and aging individuals, residents and staff.

**Recommendations: Review the extent to which these factors will impact services and proactively plan.**

---

**Finding 8.2: Recent admissions have been more behaviorally and psychiatrically complex than in the past.**

Background: One of the recent challenges at CVTC has been the intensity of the emergency admissions to the facility. Recent admissions typically were of individuals who were of higher cognitive functioning, behaviorally threatening, and on multiple medications than those typically residing at the Center. An issue of concern identified by several staff is the manner in which some recent emergency admissions have arrived at the facility. It was reported that residents were transported by ambulance and arrived at the Center with little accompanying information, only the clothing they were wearing and without a readily identified contact person who knew the circumstances of the resident. One notable recent admission was left at the Center naked, on seven psychotropic drugs, and with no accompanying clinical information. This was especially distressing because this same resident had been discharged from the Center in stable condition. The human rights advocates have been working with community services boards, the facility and the Central Office to find ways to correct this problem.

**Recommendation: Residents transitioning into the community would benefit from the development of a Community Outreach Consultation Team to aid in treatment planning and implementation. This team, comprised of professionals from various CVTC disciplines, could assist community staff in the use of Applied Behavior Analysis for the development and monitoring of behavioral interventions.**

---

**Finding 8.3: Staff voice concern about the community's ability to provide adequate care to CVTC residents upon discharge.**

Background: One challenge that faces CVTC that was identified by staff at all levels was a concern that the community was not capable of providing the level of care to clients that they routinely receive at CVTC. This sentiment was supported by comments from staff during observations of several observed annual Interdisciplinary Team meetings as well as by numerous administrative, clinical and direct care staff who were interviewed. It is very positive for staff to have a sense of pride in the work that they do with residents. We would not want to see a situation where prejudice against community placement interfered with community transition for those who would benefit from it. It is rewarding to see staff invested in and advocating for the residents they work with.

**Recommendation: None immediate.**

---

**Finding 8.4: There is a shortage of staff at all levels and with the aging of staff this will become more critical in the next several years.**

Background: Another issue that affects the treatment environment is the ability to recruit and retain direct care staff. Many supervisory staff lamented the current difficulty in recruiting competent staff in a booming local economy. One liability that several voiced was the concern that talk of closing facilities inhibited people from applying for jobs that they perceived as tenuous and possibly temporary. Another concern that is beginning to emerge at this facility, as is the case in several others in Virginia at this time is the frequency of mandatory overtime. This seems to be more prevalent within some units at the facility than others, but is becoming more common.

**Recommendation: CVTC should work with the Central Office in developing a recruitment plan. Consideration might be given to the development of a local public relations strategy clarifying future plans for CVTC and spotlighting the excellent and innovative work that occurs at this historic facility.**

---

**Finding: 8.5: Forty-two per cent of all residents live in congregate living centers housing more than 17 residents.**

Background: Recent initiatives in the Department have focused on placing individuals with mental retardation in smaller congregate living situations of 6 or fewer persons per residence. Currently CVTC is striving to cap its living centers at ten (10) residents per center. For individuals with challenging behaviors and particularly for those with higher cognitive functioning, even a living unit size of ten is too large. The Center has recently developed a small living center at Shenandoah Square to provide services for 5 men who present severe behavioral challenges.

**Recommendation: Continue to support the goal of smaller numbers of persons living together.**